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| # | Item | Hospital or Third Party Submitter Response |
| 1 | Technical Contact Name / Email / Phone | Name:  Email:  Phone: |
| 2 | Policy Contact Name / Email / Phone | Name:  Email:  Phone: |
| 3 | THA Member Name / Health System Name |  |
| 4 | Name of entity submitting ADTs if different than hospital or health system. |  |
| 5 | Hospital Facilities (or attach a list if more than one facility per health system name) |  |
| 6 | EMR / HIS Vendor (list if more than one per organization/hospital) |  |
| 7 | Desired Kickoff Date |  |
| 8 | Email group for updates and communications |  |